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ABSTRACT

Providing cost-effective services in 15 counties of Southeast Kansas, the Infant and Early Childhood Intervention Program (IECIP) teaches parents to provide daily one-to-one therapy in gross and fine perceptual motor development, speech and language development, social adjustment, and behavior management for developmentally delayed children from birth to six years of age. The primary purpose of the program has been to develop a model service delivery system for fostering the health and development of young delayed children and at-risk infants in disadvantaged, rural settings. The system involves professionals who improve the overall functioning of a large number of developmentally delayed children by traveling to the parents to teach them how to train their children. Procedures have been developed to help parents of delayed infants and young children become viable, knowledgeable teachers, case managers, and advocates. Using the principles of individualized programming, the trainer and parent develop goals, techniques, and materials for the child. In addition to IECIP services, the Kansas University Affiliated Program offers respite care for developmentally disabled individuals. This rapidly growing program includes mass media recruitment of respite caregivers and intensive training. (JHZ)

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Serving Rural Families of Developmentally Disabled in a Cost-Effective
Manner

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By

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Paper presented at the Annual Conference of the National Rural and Small
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TITLE: Infant and Early Childhood Intervention Program - Serving Rural Families of Developmentally Disabled Cost-effectively.

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The direct service aspect of the Kansas University Affiliated Program at Parsons is concentrated in the rural communities of Southeast Kansas with emphasis on serving the families of developmentally disabled children. The Infant and Early Childhood Intervention Program comprises the rural component of the KUAP.

The Infant and Early Childhood Intervention Program (IECIP) is a cost-effective rural program in 15 counties of Southeast Kansas, which teaches parents to provide daily one-to-one therapy in gross and fine perceptual motor development, speech and language development, social adjustment and behavior management to a variety of developmentally delayed children from birth to six years of age.

Over the past 11 years, the IECIP staff has learned and changed. Changes in client population, rural families, and the recognition of problems which affect the rural developmentally disabled child's future, have resulted in the development of numerous techniques and procedures. These techniques and procedures will be described in detail.



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Serving Rural Families of Developmentally Disabled
in a Cost-Effective Manner

The Kansas University Affiliated Facility (KUAF), at Parsons, is one of three UAF sites affiliated with the University of Kansas (the others are located in Lawrence and Kansas City). The KUAF receives federal funds for the purpose of providing exemplary services to developmentally disabled individuals as well as training for professionals seeking careers related to developmental disabilities. We will be discussing two of the programs included under the KUAF umbrella: The Infant and Early Childhood Intervention Program (IECIP) and the Respite Care Program.

Infant and Early Childhood Intervention Program

Developmentally delayed children create problems for their parents from the time of their birth. When the child has complex or numerous medical problems, does not start to walk or talk when he/she is supposed to, has problems eating, etc., the parenting role changes, and parents need help and answers.

Early identification and intervention has been effective in improving the progress and outcome for many DD children. If nothing else, it involves the child with persons who know how to work with the child to help him develop. According to Jorden, Hayden, Karnes and Wood (1977), programs providing early educational and therapeutic programming to meet the needs of young handicapped children and their families are reducing the number of children who will need intensive or long term help . . . with early help. In turn, these children can often function at higher levels than has been dreamed possible in prior years.

Unfortunately, early identification intervention programs are not readily available in rural Kansas. There is not a homogeneous group of DD children. Distance and cost are formidable barriers to program development. Parent groups are hard to establish. Access to the variety of professionals needed to effectively manage and program a DD child is limited. The IECIP is an attempt to address these problems.

The economy of rural Southeast Kansas is based on mining, farming and small business. In recent years, the mining business has collapsed and numerous farms and small businesses have failed. Historically, Southeast

Kansas never recovered from the great depression of the 1930s. Demographic data acquired from the office of Information Systems and Computing of the Kansas Department of Health and Environment for the years 1980 - 1985, present the following profile of this area of Kansas.

Southeast Kansas has the:

- 1) Highest unemployment rate in the state (17%);
- 2) Highest incidence of families below poverty level (11.4%);
- 3) Highest incidence of individuals below poverty level (15%);
- 4) Highest incidence of unemployed single parents with dependent children on public assistance;
- 5) Second highest incidence of families with dependent children on public assistance;
- 6) Highest incidence of teenage pregnancies (19.4%) compared to 11.7% which was the state's proportion of births of these young mothers;
- 7) Highest infant mortality rate in the state (9.1%);
- 8) Highest rate of recorded abortions (41.5%) for pregnant persons under 20 years of age;
- 9) Lowest index of adequate prenatal and postnatal care;
- 10) Highest drop-out rate in the state;
- 11) Highest incidence of illiterate persons;
- 12) Highest drug abuse rate;
- 13) Highest incidence of reported abused and neglected children;
- 14) Highest incidence of reported developmentally delayed children;
- 15) Highest incidence of premature births.

The problems of Southeast Kansas are compounded by the inability of this area to attract and keep qualified medical or educational professionals. Southeast Kansas has presented health hazards to its populace since the 1930s. Through the 1950s, Southeast Kansas had the highest incidence of tuberculosis and now the highest incidence of cancer in the state. According to National Environmental Agency, Southeast Kansas has the number one environmental health hazard in the nation--Tar Creek. At the same time, Southeast Kansas has the lowest density of qualified physicians, including obstetricians and gynecologists, to deal with those with medical problems.

Southeast Kansas has the largest stationary group of third generation welfare recipients in a four-state area including Missouri, Arkansas, Oklahoma and Kansas. Many of the families fail to promote appropriate prenatal and postnatal care for mother and child, to show responsibility for developing and maintaining a nurturing home environment for the child, and to take advantage of public education opportunities. Children in these homes frequently are delayed developmentally due to environmental as well as genetic and physiological causes. Their mothers receive inadequate prenatal and postnatal care. Most are raised by uneducated parents at home until they are sent to public school programs or institutionalized. By the time the child enters an educational program, his/her future has already been largely decided. An educational program alone cannot overcome the long-term effects of a family whose primary goal is subsistence.

Parents limited educationally and economically frequently have difficulty nurturing and teaching their disabled children born with intermittent or chronic medical complications. These parents cannot afford needed consistent medical attention. They do not understand the ramifications of a child's diagnosis and that the medical plan is designed to reach a successful and beneficial outcome for the child. Consequently, when their child needs medical help, they frequently do not schedule or keep medical appointments or follow prescribed interventions.

Programs for children with developmental delays, ages 0-6, in Southeast Kansas are extremely limited. The public schools have developed three special preschools in a 15-county area which deal with a small percentage of the special needs children, ages three years and older. Head Start Programs work only with 4-year-old and older children in Southeast Kansas. Only 10% of their case load can be developmentally delayed.

Although the needs of developmentally delayed children begin at birth, in many rural areas intervention programs are nonexistent for such children before age five. Programs providing early programming for young handicapped children and their families can reduce the number of children needing intensive or long-term help. The primary purpose of the Infant and Early Childhood Intervention Program was to develop a model service delivery system for fostering the health and development of young delayed children and unborn at-risk infants in economically deprived rural settings. The system involved infant and child development professionals who improve the overall development of a large number of young developmentally delayed children by traveling to the parents to teach them how to train their children. Procedures were developed to help parents of delayed infants and young children become viable, knowledgeable teachers, case managers and advocates. Such procedures will be disseminated to others serving delayed populations in similar locations.

The Infant and Early Childhood Intervention Program began as an inter-professional, interagency program between the KUAF and existing service agencies involved with developmentally delayed children and their families, in a sparsely populated, rural area of Southeast Kansas. The program

involved the child's physician, county Public Health nurses, social and rehabilitative services social workers, public and independent school personnel, Mental Health Department psychologists and counselors, and the child's parents. Initially, we informed and trained each other in regard to functions and roles. The KUAF educated its sister agencies regarding the need to provide developmentally delayed children appropriate medical and educational procedures and therapies as soon after birth as possible.

We decided each agency would act as a broker for children initially identified by that agency. In other words, the agency would direct the children to other needed services provided by its sister agencies.

At first, KUAF staff were primarily interested in initiating procedures for identifying developmentally delayed or at-risk infants at birth; however, the other agencies expressed their concern with the needs of existing developmentally delayed children in their communities who were not receiving help. At that time (approximately 10 years ago), in our region of the state, parents of even identifiable DD children, such as Down's Syndrome, were not informed of their child's problem until the child was two- to three-years old. Then, the child was directed to a state institution. Thus there was a need to provide services for children regardless of age.

We first attempted a transdisciplinary training and service model. The remnants of this model continue in the areas of behavioral management, social work, self help, early speech and language training, and parent involvement. However, today, the basic system has social workers doing social work, speech therapists training speech and language techniques, psychologist dealing with behavioral problems, and so on. The main persons actually involved in the transdisciplinary training are the child's parents.

Basic premises: There are some 19 basic premises of the IECIP. These are as follows:

- 1) When parents think there is something wrong with his/her child, we will work with them to discover if there is a problem
- 2) Our purpose is not to diagnose or name the child's condition; we want to determine where the child is developmentally, identify and eliminate factors impeding the child's ability to develop, learn how to best teach the child, and take the child forward developmentally--we do not concern the parent with where the child should be.
- 3) It is important to initiate remediation on a developmental problem as early in a child's life as possible.
- 4) The child's parents are the authority on their child, and they are our peers; it is their responsibility to raise their child, not ours--we work with each other.

5) The child's parents, their attitudes, and the environment have the long-term overriding effect on the child's development and eventual outcome.

6) Parents do many things right for a special child without intervention.

7) Parents are capable of training DD children in most areas of learning with direction and information from other experienced professionals.

8) For continuity in long-term learning, for continuity of programming, for intensive training, for maintenance and generalization of learned skills, and for an affordable program, we believe the child's parents must become the teacher of their DD child.

9) We never tell the parents we will teach their child; we do train the parents what and how to teach their own child.

10) DD children have problems synthesizing the separate skills they are taught for effective application.

11) The most important need of a special child is environmental adaptation--to train the child to exist and function in his home environment (home, grocery stores, restaurants, movie theaters, churches, etc.. Next comes reading, writing and arithmetic

12) The child's rate of progress determines our objectives and goals; diagnoses and prognosis are kept tentative.

13) The child's improvement is based on time; the amount of time spent in one-on-one training experiences at the child's learning level is a crucial factor in determining the child's progress.

14) We are involved with the child for a long term; consequently, we emphasize continuity in programming.

15) Learning should take place where it can be maintained and generalized.

16) Programs which take the DD child away from the places and persons instrumental in the child's development are at best ineffective and at worst destructive; such programs attempt to serve the DD child under the guise that professionals can do it better than the parents and with the child being taught in situations limited in time and opportunities and separated from the natural environment--in some cases the parent is not even told what the child is being taught and parents are seldom involved in the training.

17) We disagree with the segregation of most DD children by their parents and educational systems from their environment and experiences with "normal" children. The appropriate model for a DD child is a normal child.

In turn, this is a good time for normal children to learn to understand and accept DD children.

18) In many special education systems, the DD child is taught how to succeed in school but not in his home environment or community. The parent is the child's main teacher of how to live outside an institution.

19) Our goal is to make the DD child a future functional independent, self-supporting adult.

Description of IECIP Services

The IECIP is an interdisciplinary and transdisciplinary approach serving the developmentally disabled population, primarily ages 0 to 6 years. The IECIP provides services in the areas of gross and fine perceptual-motor development, speech and language development, socialization, behavior management, self-help, environmental adaptation, and evaluation. The IECIP is available to the Southeast Kansas population at no charge. The IECIP is funded by the University of Kansas/Bureau of Child Research core grant and matching federal/state funds. The administrative cost of the program is approximately \$200 per client, per year. This cost plus low travel to centrally located provision points for families makes the IECIP's parent training approach feasible and financially possible.

The total population served by the IECIP is approximately 350 DD children and their families. Diagnosis for some of the children involved in the IECIP are autism, cerebral palsy, Downs Syndrome, microcephalus, hydrocephalus, Russell Syndrome, Williams Syndrome, Pierre Robin syndrome, as well as other known and unknown forms of developmental delay. The characteristics of the environment and population in Southeast Kansas predispose most of the children we work with to environmental neglect and delay. The program covers a region of 15 Southeast Kansas counties. There are 18 provision points (not counting home visits) in specific cities in the region where weekly or bimonthly contacts are made with the child and their parents. The program is held in the offices of county public health, mental health, social and rehabilitation agencies, hospitals, city halls, public/private schools and some homes.

The IECIP team travels into the catchment areas to the designated provision points to serve the individual child. In addition, when the child is ill, extremely young, or there are transportation problems, the IECIP staff provide services in their homes. This tends to alleviate the expense of travel that hinders center-based programs with lower socio-economic persons. Many low-income parents cannot afford travel or do not have transportation.

The IECIP model involves the development of parent competencies in implementation and evaluation of developmentally/behaviorally based intervention programs. Based on the principles of individualized programming, the trainer and parent develop the goals, techniques and materials for the

child. The program is geared to the age of the child, chronologically, physically and emotionally. If a client is an infant, the program emphasizes motor, communication, and cognitive development. If the client is older, the program directs itself toward self-help, communication, sensorimotor integration, the interpretation of the environment, preparedness to become an adult, and school readiness. The program also directs its efforts toward aiding parents in handling the inappropriate disruptive behaviors of their children.

Services delivered are specific to the client's needs and disabilities. The gross/fine perceptual-motor component breaks the specific needs into two areas of contact-motor development and sensorimotor integration. Direct application of remediation is dependent under which level the client is functioning. The speech and language component encompasses the levels of pre-speech and receptive and expressive language, pre-academic readiness, and behavior management. The psychological component provides complete cognitive and adaptive behavior testing and instruction in behavioral management techniques for handling inappropriate and disruptive behaviors. The social work component offers parental counseling, behavior management techniques, respite care programs, and home-based intervention in crisis situations. The IECIP thus offers an interdisciplinary approach to the rural-base environment through four components.

✓ Interactions between the IECIP staff, the child's physician, public health nurse and social worker extends the care of the DD child to involve his hygienic, medical, and welfare needs. Approximately 40% of the DD children referred to the IECIP come from the child's physician, public health offices, public schools or the social welfare systems. The majority of our referrals are via the parents of DD children we are presently working with or have helped in the past.

Following referral, the child is placed on the waiting list for his/her catchment area, or entered in the program at a time and place where the IECIP staff, the child and the child's parent(s) can consistently get together. The initial contact with the child and parent may last minutes to hours and the child's needs may be observed and evaluated by one or all the IECIP staff members with the help and input of the child's parents and other family members. The staff members' abilities to involve the child's parent(s) in the description of the his/her problems and needs is considered an important element in training them as the child's teacher. The parent leaves the initial meeting with an assignment involving the recording of observable behaviors important to determining the child's present level of motor development, communication, cognition, socialization, or the child's aberrant, counter-productive activities considered in conflict with the child's growth and development, as well as a few specific training goals and techniques to use daily with the child.

The above system involves the parent(s) immediately in the description of their child's developmental problems and procedures they can do to improve their child's development. The staff member must meet three criteria when

he makes an assignment. One, the assignment must offer observable improvement in the child's development; two, the assignment must be something the parent can do; and three--and most importantly--the assignment must be something the child can do. These three criteria result in a feasible, practical and workable program for the child.

After the initial meeting, trainers, parent(s), and child meet weekly or bi-weekly. To achieve program criterion, each meeting with the child and parent involves essentially the following format. The child, parent and staff member discuss and evaluate together the success or failure of the last assignment. The staff member asks the child's parents about their experiences with the past assignment, often having the parent demonstrate the procedures they have consistently performed with their child. This procedure tells the staff member if the parent has been doing the assignment and how the parent has been doing the assignment.

Young children often perform better with their parents working with them, thus allowing the staff member to observe where the child is, as well as what problems the parent(s) is having working with their child. The staff member tells the parent what the parent has accomplished with the child. The parent and the staff member then work with the child to determine whether to continue the present assignment, change the assignment, because the procedure is not working or move to the next level of training. The staff member discusses the purpose of the next assignment, models and explains the criteria for successfully performing the procedure, and practices the procedure with the parent working with the child until both know what will be happening to the child until the next meeting.

To insure understanding and application of the assignments, the staff member is on call to the parent by phone or in person. Before the parents leave the meeting, they are given a written description of the assignment, as well as any materials they will need, (not available in the home) for doing the assignment. Often materials are made by the parent and staff member for the child. We have found parents and their child use more consistently and take better care of materials they help make. The parent tends to become self sufficient in meeting the needs of the child and less dependent on others.

Contact between the staff member, child and parent is intense, with particular emphasis on educating the parent on the specific problems of their child, defined over time by the IECIP staff and the child's parents. The parent is the focal point of therapy with the particular child. They determine what, how, and how much will be done. Grossly, we find parents able to consistently achieve more over a long period of time with their child than any other present system.

The home and community environment becomes the child's therapy room. The parents become the child's developmental specialists--teacher, case manager and advocate. By working with parents, the IECIP staff is able to affect many more children than they could working individually with a child, thus

increasing the number of children helped in the catchment without a concomitant increase in numbers of hired professionals. Each of the IECIP staff members is impressed with the greater growth in child development (over time) with the parent being the trainer than was ever expected when working with individual children in private, public or university therapy programs.

Support Programs for DD Children

KUAF at Parsons personnel have developed cooperative services for DD children and their families with Kansas Crippled Children (KCC) and Parsons State Hospital and Training Center (PSHTC). Each month, the KUAF at Parsons and PSHTC offer free audiological screening involving puretone threshold testing, tympanography and localization testing with noisemakers for any child suspected of having problems in the 15-county catchment area. The KUAF and KCC provide a bi-monthly orthopaedic clinic involving orthopaedic surgeons, nutritionists, prosthetic specialists, physical therapists and social workers. The KCC program also provide genetic counseling and pediatric cardiology.

Over the ten years the IECIP has been in existence, the staff of the program, with the first-hand help of the parents of DD children, have developed a listing of professionals in the area who are willing and capable of treating children with special problems. This list includes dentists, orthodontists, pediatricians, pediatric allergists, optometrists, otorhinolaryngologists and audiologists. The appropriate management as well as the diagnosis and treatment of the recurrent and special medical problems of DD children is a major factor affecting child development.

Respite Care Program

In addition to the services provided by the IECIP, the UAF's Respite Care Program offers another set of important services to parents of handicapped children in Southeastern Kansas. The purpose of the KUAF Respite Care Program is to provide those persons responsible for the care of developmentally disabled individuals with intermittent, brief periods of relief or time off from the heavy demands and constant stress of caring for their disabled child or adult. Respite care offers not only relief to the family, it provides for growth, development and normalizing experiences for the disabled individual through interaction with others in the community. It is the intent of the respite service program to reduce the need for institutional or other out-of-home placements, while strengthening the coping abilities of families and improving the quality of family life.

Since 1982, the KUAF Respite Program has provided community-based respite in the rural counties of Southeast Kansas. The substantial and rapid growth of the program demonstrates the need for community-based respite and the ability of professionals in the field of special education to recruit,

train and place volunteers in temporary caregiver roles. Consequently, the families can have planned time for recreation or renewal activities as well as time to attend to emergencies. The two types of respite offered through the program are:

Companion/sitter service--trained persons provide care in the disabled client's home;

Respite care home--trained persons provide care in their homes, which are state licensed.

Recruitment. Mass media campaigns are used to recruit potential providers and inform families with disabled members about respite. Most of the campaign is conducted utilizing no-cost forms of advertising, such as a) public-service announcements through radio and television, b) news releases and feature stories in newspapers, c) interviews on radio talk shows, and d) presentations to community, church and school organizations. The only types of paid advertising used to date are a) posters announcing the respite services and upcoming provider training workshops, b) brochures describing the program, and c) mass mailings to education, social service, health care, and church personnel.

Training. Providers must be at least 18 years of age and volunteer time to training preparation for respite. The training provided through the KUAF Respite Program includes an all-day workshop and "hands-on" training experiences. In addition, once a family requests respite and a provider agrees to provide the care, the provider is obligated to train with that family until the family and provider are satisfied that the provider will be able to competently meet the care requirements for the disabled person. Additional requirements include health and security clearances, letters of reference, and a screening interview conducted by the Respite Care Coordinator to determine the applicant's willingness and ability to provide respite and current skill levels. Potential providers are responsible for obtaining Cardio-Pulmonary-Resuscitation (CPR) Certification through community agencies offering such training (such as the American Red Cross).

How the KUAF respite program works. Parents are asked to enroll their son/daughter in the program prior to requesting respite. This assures that the specific care needs of the disabled individual are well known so providers can be adequately trained. Once enrolled, the family calls the Respite Care Coordinator (using the toll-free number) to request respite. The coordinator then contacts a provider and arranges for the service. After the placement is agreed upon by the parents, provider and coordinator, a pre-placement visit is arranged in preparation for the respite.

Following respite sessions, providers are reimbursed for their services and both the providers and the parents are asked to complete evaluations on the placement. Payments do not occur directly between families and providers. The provider submits a bill to the coordinator and receives payment through the program. The program bills the family for the services based on the financial agreement determined when the family enrolls. A sliding scale is used to determine family fees for services.

Program funding. The budget of the KUAF Respite Program consists of two components--organizational and direct-service funding. In regard to organizational funding, the program is sponsored by the Kansas University Affiliated Facility at Parsons which supports the program in cooperation with the Parsons State Hospital and Training Center through the contribution of all organizational, administrative and supply costs. As for the direct service funding, donated monies and family fees for services are used to pay for the direct costs of providing respite to clients. This includes incentive fees to providers at a rate of \$3.00 per hour for 1 - 7 hours of respite or a flat rate of \$25 for each 8- to 24-hour session plus mileage reimbursement to providers who must travel out of their home community to provide respite. Providers are self-employed, contracting with the program to provide services, and are not employees of the University.

Start-up funds for the program were provided by the Frederic L. Girardeau Memorial Fund which is administered through the University of Kansas Endowment Association. This trust fund was designated to support community-based services for developmentally disabled individuals. In addition, respite services have been supported through the generous contributions of individuals, industry and community organizations, and family fees for services.

Program growth and replication of services. Respite services are now available for the families of developmentally disabled individuals in six rural Kansas counties, with 21 sitter/companions providing respite for 42 disabled clients. The number of hours of respite provided has increased from 60 hours in 1982 to 2,385 for 1985. The goal of the program is to make respite available in a 9-county area to any family with a handicapped member requesting the service. As each area is targeted for recruitment and fund raising, the initial steps for implementing and supporting the program are replicated.

Future Directions

We plan to continue our IECIP service model in the future, but anticipate diversifying in some significant ways. Many of the diversifications will be designed to meet our responsibilities as a UAF--to develop "state-of-the-art" services and to communicate our methods to a broad audience of individuals involved with handicapped children. In addition, there will be some changes related to the Respite Care Program.

One activity we will undertake in the future involves a research project designed to compare the effectiveness of the parent-directed model we have developed to the more traditional therapy model used in the public schools. While only in the planning stages, the project will involve two studies--one involving speech services and one involving motor development. Public school speech and physical therapists will treat some children using the parent-directed model and some using the traditional model. Outcome data will be collected in order to determine which of the models appears more effective.

To demonstrate the replicability of the service model, we are planning to help initiate similar services in a region of the state which we currently

do not serve. Therapists and teachers in that region will be assisted in learning to provide parent-directed services by IECIP staff. We feel that it is important to determine if the philosophy and methods which we have found so effective can be used by other professionals.

Based on the results we have achieved to date, and on anticipated success in the two projects described above, we will be making an effort to communicate the details of the parent-directed model to audiences on a state and national level. We intend to attend state, regional and national conferences of professional organizations to discuss the merits of the parent-directed approach. In the future, we will be videotaping examples of our sessions with the clients and their parents to illustrate the procedures and styles we use in encouraging and teaching parents to work with their handicapped children. We are also considering the possibility of conducting training workshops for professionals attending conferences. In regard to professional journals, we intend to submit articles detailing the philosophy of the program, the procedures we use, and the results of the research project mentioned above.

Along this same theme, we feel a need to provide additional practicum opportunities for students studying speech and hearing, adaptive physical education, physical therapy, psychology, special education, etc. While we have done some such training in the past, we intend to increase the level in the future (i.e., more students and longer practica).

Still in the planning stages is a potential project designed to demonstrate the feasibility of a parent-training program for decreasing the risk of developmental delay among infants conceived, born and raised in poverty conditions in rural areas, such as Southeastern Kansas. The components of such a program would include: prenatal identification; professionals as parent trainers and consultants; parent-aides; parent-training classes; parent support group; community outings; parent competency demonstration. In addition to our current staff, this project would involve the addition of six Parent-Aides and a Nurse who would serve as the Parent-Aide supervisor and medical representative of the transdisciplinary team.

In regard to the Respite Care Program, we are seeking greater levels of community financial support for the incentive reimbursements paid to providers. While administration of the program will continue to be provided through UAF funds, we will be seeking to raise enough donations from community, civic and church organizations, industry, business and individuals to cover the funds budgeted for provider payment.

Finally, we plan to carefully review the current training program for respite providers. While most of the topic areas appear appropriate, we would like to convert the training to a competency-based mode. This would help to insure that new providers do, indeed, acquire the skills that we are attempting to teach.

In summary, we are quite encouraged by the success of our current programs and intend to continue them in much their present form. Our plans for the future include at least one systematic research project related to the

effectiveness of the parent-directed approach, a replication of the service model in another region of the state, the provision of additional student practicum activities, increased dissemination activities, changes in the respite provider training program, and the development of more community support for the provider payment portion of the Respite Care Program.

Jorden, J., Hayden, A., Karnes, M., & Wood (1977). Early childhood education for exceptional children. Reston, VA: Council for Exceptional Children.

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